Beneficiary Billing Claims Process

On MMIS

KEESM 7532.4

Form ES-3170
Updated 11/09

BB CLAIMS

- ✓ BB claims are entered in the **few** instances in which a consumer receives medical services from a non-Medicaid provider.

- ✓ BB claims can be entered for services received from a Medicaid provider who is unable to bill for a particular service. These instances should be **rare.** Providers are not required to bill Medicaid if a card isn't presented at the time of service. However, most providers are willing to bill for services if the consumer has not privately paid for the services. The recommendation is to pursue the provider billing method first, then use the beneficiary billing process for these claims when necessary.

- ✓ If a card is presented at the time of service, the provider **must** bill for covered services. You **do not** use the Beneficiary Billing process to allow these expenses even if the consumer requests it. Contact with the provider may be necessary to insure they intend to bill for the service. A referral to the provider representative could also be made in this circumstance to encourage timely billing on the part of the provider.

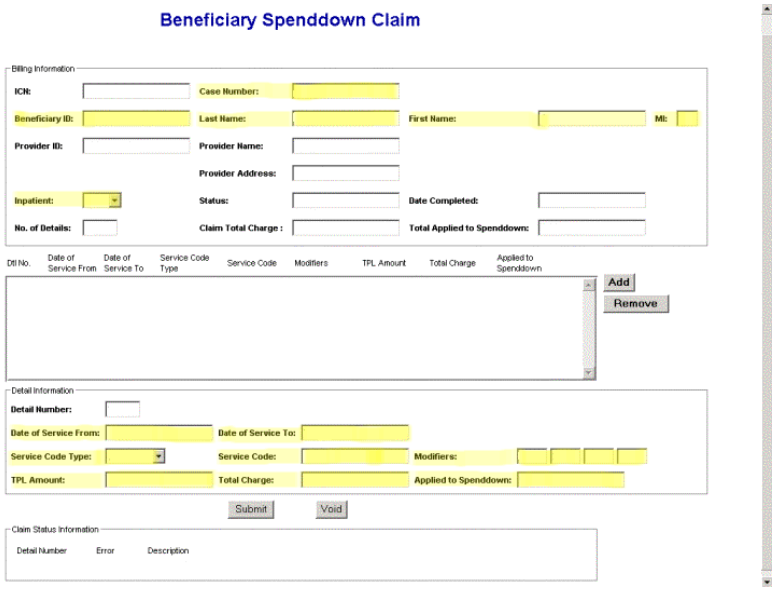
- ✓ The Beneficiary/Patient Billing Form (ES-3170) is given to the consumer **only** when it is needed. If a medical bill is received and contains all the necessary claim data elements, a form is not necessary as the bill can be entered into the MMIS system right away.

- ✓ Do **not** access the **Beneficiary Spenddown Claim window** until you have all of the needed information about each service and TPL has been resolved for all the services.

- ✓ Do **not** use a pseudo procedure code if a procedure code exists for that particular type of service. Almost every type of service has an available procedure code, and you may contact your Medicaid Liaison to help you obtain the appropriate codes.

Take a look at the following pages to see which fields on the **Beneficiary Spenddown Claim window** the eligibility worker completes and which ones are completed by the interChange MMIS system.

MANDATORY FIELDS COMPLETED BY THE ELIGIBILITY WORKER



Beneficiary ID Number: Enter the correct Beneficiary ID number for the person who received the service.

Last Name, First, Middle Initial, and Case Number: Once the Beneficiary ID number is entered, you tab or click your mouse on the next available field and the system will automatically populate the name and case number fields.

Inpatient: Enter yes or no, based on whether the service being allowed as a BB claim was performed in an inpatient setting.

Date of Service From: Enter the beginning date of service in this field. MMDDCCYY is the format of this field. The 'To' and 'From' dates will probably be the same date for a majority of services being allowed through the beneficiary billed process unless they are inpatient services.

Date of Service To: Enter the ending date of the service in this field. If not inpatient, this date most likely will be the same date as the 'Date of Service From' date. MMDDCCYY is the format of this field.

Service Code Type: Use the drop down box to select from ADA, CPT, HCPCS, NDC, or REVENUE.

Service Code: Enter the service code as provided to you by the provider.

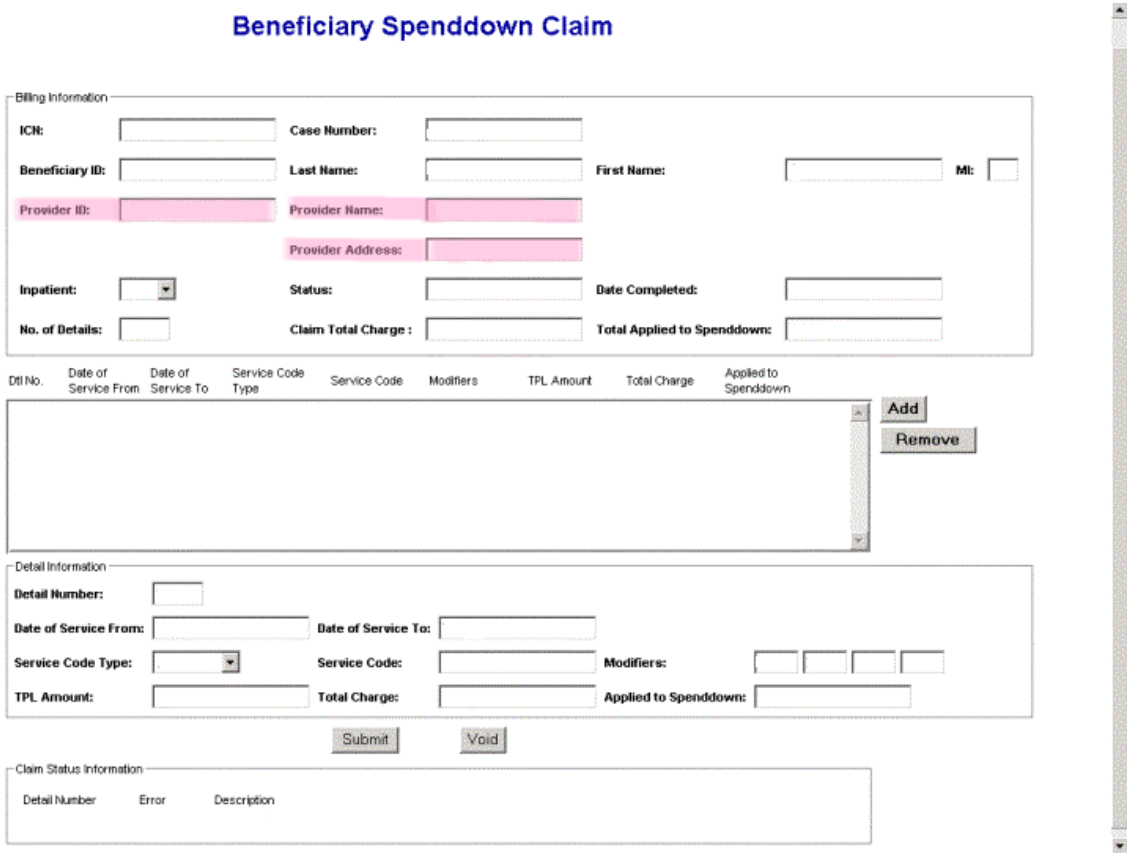
Modifiers: Enter the service code modifier(s), if any, as provided to you by the provider.

TPL amount: Enter the amount, if any, of TPL reimbursement and write-off for the service. If none, enter 0.00. Do not enter the dollar sign. Also, the system will automatically make the cents you do zero if you do not add the decimal point (e.g., enter 24 and the system will automatically change to 24.00 when you tab to another field).

Total Charge: Enter the total charge for the service prior to any TPL reimbursement or write-off amounts.

Applied to Spenddown: Once the 'TPL Amount' and 'Total Charge' is entered, you tab or click your mouse on the next available field and the 'Applied To Spenddown' field is automatically calculated by the system.

OPTIONAL & RECOMMENDED FIELDS
COMPLETED BY THE ELIGIBILITY WORKER

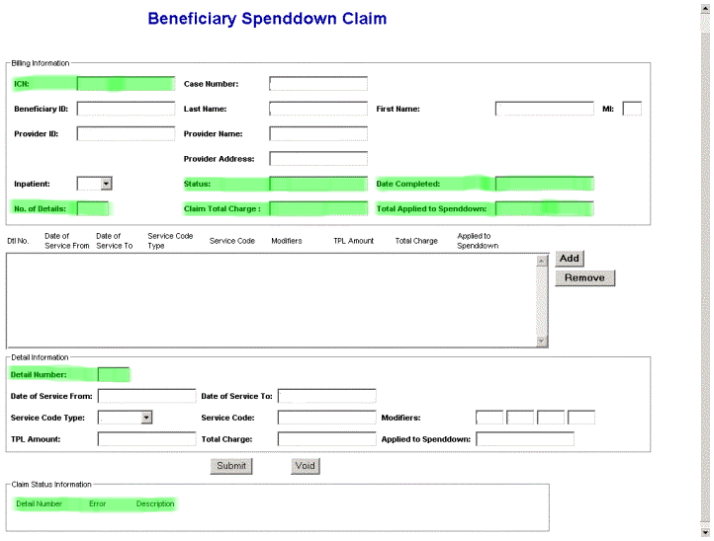


Provider Identification: If the provider is a Medicaid provider, enter the Medicaid provider number in this field.

Provider Name: Enter the name of the provider, clinic, etc. in this field.

Provider Address: Currently, this field is not long enough to enter the entire address. Enter enough of the street address to later aid in determining the specific provider. This field will be expended to allow entry of the entire address (including city and state).

SYSTEM ASSIGNED FIELDS



Billing Information

ICN: Once the claim is submitted, the system automatically assigns an Internal Control Number to the claim. All Beneficiary Billed Claims have an ICN number that begins with 76, so claims can be easily identified on the Spenddown Claim window that were BB claims.

Status: This field is automatically populated with one of the following status codes:

- ✓ PAID - The claim has been entered and applied to the spenddown through the BB claims process
- ✓ VOID - The claim that has been voided by a staff member.
- ✓ IN ERROR - The claim was entered, but has an error message appearing in the bottom portion of the screen. (see error field description below)

Date Completed: The system indicates the date that the claim was submitted to the MMIS.

No. of Details: The system shows how many separate procedure charges were entered on this claim.

Claim Total Charge: The system tabulates the sum from each 'Total Charge' field on every detail entered for the claim.

Total Applied to Spenddown: The system tabulates the sum from each 'Applied to Spenddown' field on every detail entered for the claim.

Detail Information

Detail Number: The system assigns a detail number to each procedure that is entered.

Claim Status Information

Detail Number: The detail the error refers to.

Error: If data entered on the window is not complete, short error codes will display.

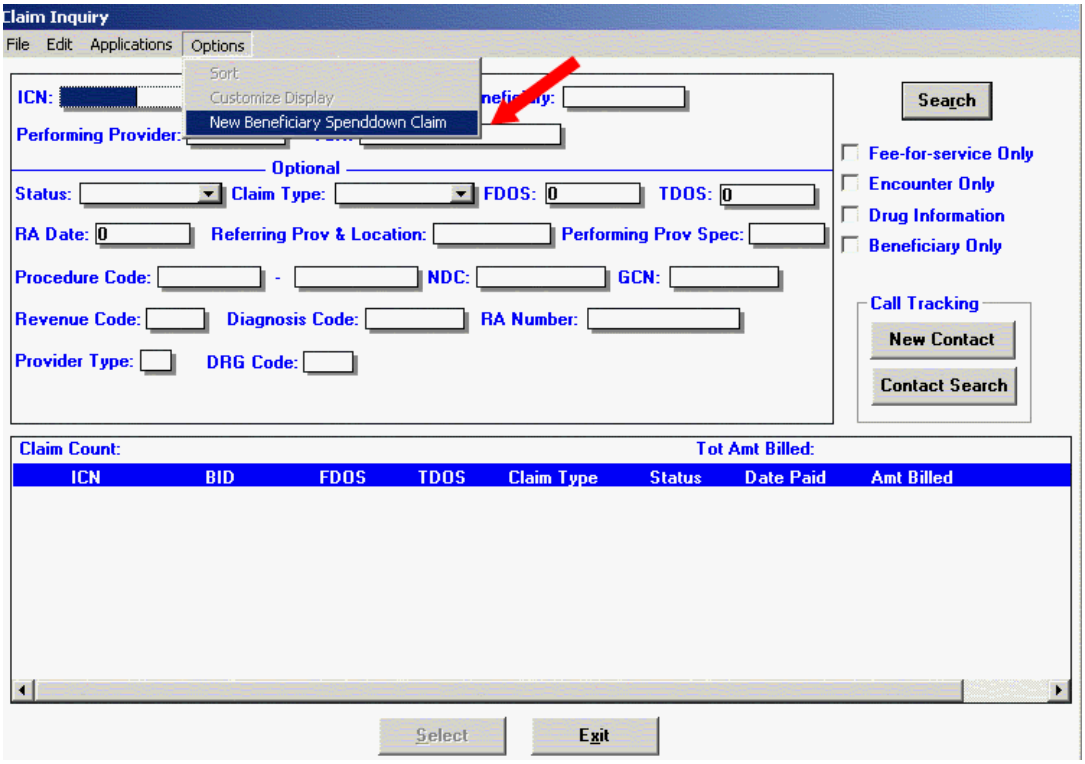
Description: This field was designed to perform some validations before processing the claim. Following is a list of validations the window performs before processing:

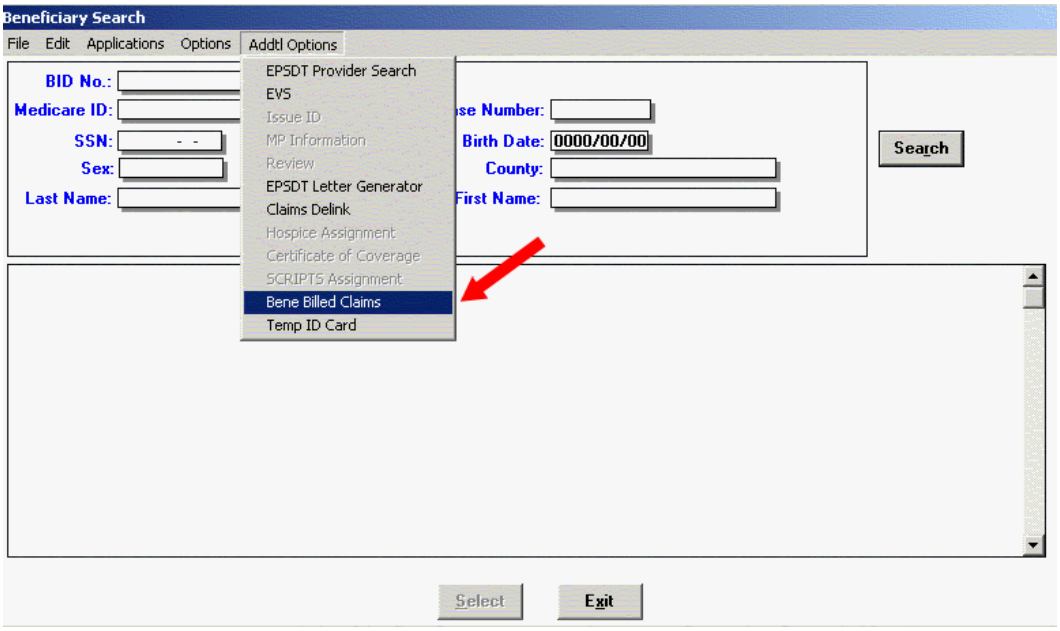
- ✓ Total Billed Amount must be numeric.
- ✓ Amount Billed is numeric.
- ✓ Spenddown Paid is numeric.
- ✓ Spenddown Paid is not greater than Amount Billed.

- ✓ From Date of Service must be a valid date.
- ✓ To Date of Service must be a valid date.
- ✓ To Date of Service must be greater than From Date of Service.
- ✓ The Detail Section must have at least one record.

HOW TO ACCESS THE BENEFICIARY SPENDDOWN CLAIM WINDOW

There are multiple ways to access the **Beneficiary Spenddown Claim window**. The most common ways are pictured below and use either the Claims Subsystem "Options" or the Beneficiary Subsystem "Addtl Options" drop-down menus.





REVIEWING THE ES-3170 (BENEFICIARY/PATIENT BILLING FORM)

Using The Form

Before giving this form to a consumer or provider to complete . . .

- ✓ make sure that the medical expenses meet the Beneficiary Billing Claims processing guidelines (it is not one of the four things entered on **MEEX** and is not something that can be provider billed).
- ✓ write the Beneficiary's name and ID number on the form itself.
- ✓ add your name, address, phone, or fax number in the 'Return To' box on the form.

Reviewing the Form

Once a completed ES-3170 form is received, the eligibility worker should carefully review the information prior to entering the claim on the **Beneficiary Spenddown Claim window**. The form is really not a big difference from how spenddown expenses were handled prior to 10-2003 changes. The worker has the obligation to make sure the expense meets the criteria of being medically necessary and that all potential Third Party Liability is utilized before allowing the expense.

Not Using The Form

Please note that not all medical expenses, allowable through the Beneficiary Billing Process, will be able to be reported on the ES-3170 form.

Examples

- The ES-3170 form cannot be used when a consumer is claiming medical transportation costs, from a friend or neighbor who is not a Medicaid provider, since they would not know how to complete the form. They don't know the procedure code for medical transportation. In this case, verify the mileage and medical necessity as required by Appendix P-1. Compute the allowable costs by taking the mileage times the state reimbursement rate of $ .36 a mile. Obtain the medical procedure code for transportation from your Medicaid Liaison. Enter the Beneficiary Billed Claim on the MMIS system.

- The ES-3170 form may not be applicable to home modifications. If a consumer has documented an allowable home modification and received services for the modification from a handyman, a plumber, a carpenter, etc; the provider is not going to be able to complete information about medical service codes and insurance information. Contact your Medicaid Liaison for guidance on these procedures. Pseudo procedure codes may be necessary.

STEPS IN ALLOWING BENEFICIARY BILLED CLAIMS

1. Verify that the medical expense submitted as a Beneficiary Billed Claim is for a beneficiary approved on a Medically Needy benefit plan.

   Verify this by accessing the **Beneficiary Eligibility window** in the Beneficiary Subsystem of the interChange MMIS system. However, information on the KAECSES system may also be used to verify that a person is coded **IN** on a Medically Needy case.

2. Check to see that the expense falls within the Medically Needy base period.

   If it is not for a date within the base period, this expense is not a Beneficiary Billed claim.

3. Check to see if the expense is something that could or should be provider billed.

   If it is a service received from a Medicaid provider, inform the consumer the provider must bill Medicaid for the expense, or check with the provider to ensure they will not be billing for the service. This is not a Beneficiary Billed Claim until you have verified that the Medicaid provider will not bill for the service.

4. Make sure the expense is not one of the four things entered on the **MEEX** screen. (Nursing Facility Charges, Health Insurance Premiums, Past Due and Owing Bills, Expenses for Persons Coded **DI** on **SEPA**)

   If it expense is one of the four things allowed, make the appropriate allowances on the **MEEX** screen. This is not a Beneficiary Billed Claim.

5. Check the MMIS for any additional TPL coverage for this beneficiary.

   If there is additional TPL, ascertain if TPL has been pursued for this expense. If there isn't any new TPL coverage, you may continue processing the Beneficiary Billed claim.

6. Make sure you have all the necessary data about the services including date of service, inpatient or outpatient, procedure code type, procedure code, modifiers, if TPL is resolved, amount of the services, and that the expense is the consumer's responsibility to pay.

   If you do not have all the necessary data, contact the consumer or provider to resolve outstanding data issues about the expense. You may also contact your Medicaid Liaison if you need help obtaining procedure codes for services provided by Non-Medicaid providers. Do not enter a service as a Beneficiary Billed Claim until you have all of the information about the claim.

7. Check the interChange MMIS system to verify if the spenddown is met. You should do this by accessing the **Spenddown Claim window**.

   If the spenddown is met, file the expense. It does not make a difference on the spenddown case if the claim is entered into the MMIS system. You may also pursue the expense as an allowable FS medical deduction, if appropriate.

8. You are now ready to access the **Beneficiary Spenddown Claim window** within the MMIS system and enter all of the details about the Beneficiary Billed Claim.

9. Complete all mandatory and recommended fields on the window for each procedure submitted for the provider. Remember, a different provider or beneficiary will require a separate **Beneficiary Spenddown Claim window** be completed.

   Once all of the details about the first procedure are entered, click on the 'Add' button and enter details about the next procedure until all procedures have been added.

   If you notice an error on a detail, make appropriate corrections before clicking on the 'Add' button.

   If you notice an error on a detail after having clicked on 'Add', then select the detail that requires correcting by clicking your mouse on the line (it should be highlighted in light blue). Then click on the 'Remove' button. You will have to re-enter all information about that detail and click 'Add'.

   The **Beneficiary Spenddown Claim window** does not limit you to the number of procedures you may add per claim; however, it is recommended that you enter approximately five procedures per window. More than five details creates a greater potential for an error. Once a claim is submitted, it cannot be changed but must be voided and re-entered.

10. When all procedures for the provider have been entered, review the window to ensure all details are correct, and then click on the 'Submit' button. This submits the claim to the MMIS and applies the total amount of the claim toward the remaining spenddown. Once a claim is submitted, the system assigns and Internal Control Number (ICN) to the claim. All Beneficiary Billed Claims have ICN numbers that begin with 76.

    If you notice an error on the claim before hitting 'Submit', make corrections to the detail information by selecting the detail that requires correcting. Click on the line (it should be highlighted in light blue), and then click on the 'Remove' button. Re-enter all information about that detail and click 'Add'.

    If you notice an error on the claim after having clicked 'Submit', then you will have to void the entire claim and re-enter the information. Instructions for voiding claims can be found in this training material or in your MMIS training section, "Beneficiary Billed Spenddown Claims Entry", page 12.

11. File the claim documentation in the case file and document in the log the action that was taken on the submitted claim.

12. If the spenddown remains unmet after the Beneficiary Billed Claim is allowed, the MMIS will send a Spenddown Summary notice at the end of the week informing the consumer the expense has been allowed.

    If the Beneficiary Billed Claim is enough to meet the spenddown, the MMIS will send the consumer a Spenddown Completion Notice informing the consumer about all expenses within the MMIS that were used to satisfy the spenddown. Remember, if the expense that satisfied the spenddown has a PPP indicator of 'N', (all Beneficiary Billed Claims do) the case is sent to the adjustment unit. There all bills are reviewed and non-PPP claims are applied to the spenddown first. (see page 40 of the New Spenddown Process Section of the October Medical Change Training Material for more details)

EXAMPLES

A Sample Of Non-Medicaid Provider Transportation Costs

Jerry has … for the base per… begun rehabilita… center is 20 miles fro… onday, Wednes… is taking him to a… $30 a week for takin… these transpor…

Action

- ✓ T… ek, the p… t a M…
- ✓ S… tten ve… week time pe… h tr…
- ✓ T… e code for m… mile - ve… sted in… ate with yo…

T… They are:
A0200 - Non-emergency transportation; ancillary: lodging - escort. This is for lodging expenses when travel is more than 150 miles and staying overnight.
A0210 - Non-emergency transportation; ancillary; meals-escort. This is for meal expenses when traveling more than 150 miles and staying overnight.

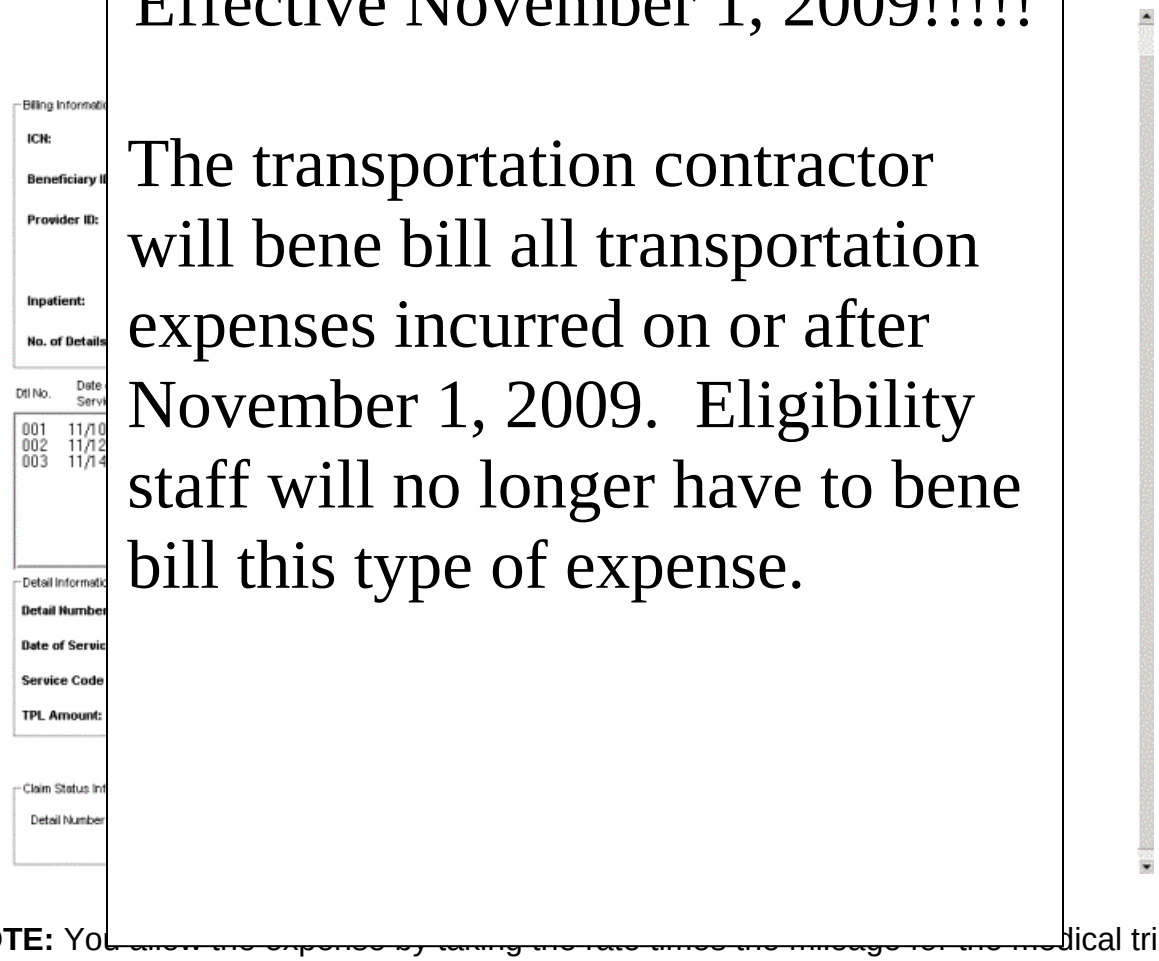
- ✓ The worker calculates that Jerry incurs 40 miles per treatment x state travel reimbursement rate of $ .36 per mile (*for most current state rates refer to* *http://da.state.ks.us/ar/employee/travel/trifold.pdf*).

Effective November 1, 2009!!!!!

The transportation contractor will bene bill all transportation expenses incurred on or after November 1, 2009. Eligibility staff will no longer have to bene bill this type of expense.

Entering Transportation Cost

✓ The worker enters the transportation costs one week at a time on the **Beneficiary Spenddown Claim window**. The completed window is shown here



NOTE: You allow the expense by taking the rate times the mileage for the medical trips. You would want to ensure you aren't allowing more against the spenddown than the consumer is actually responsible to pay.

In this situation, it appears to be more that what the consumer paid on a weekly basis, but if you look at the entire month of November you'd see that Tom was paid $120 total in that month for transportation. We will allow the actual mileage for the medical trips on a trip-by-trip basis until we reach the $120 limit for that month.

A Sample Of Medicaid Co-Payment Costs

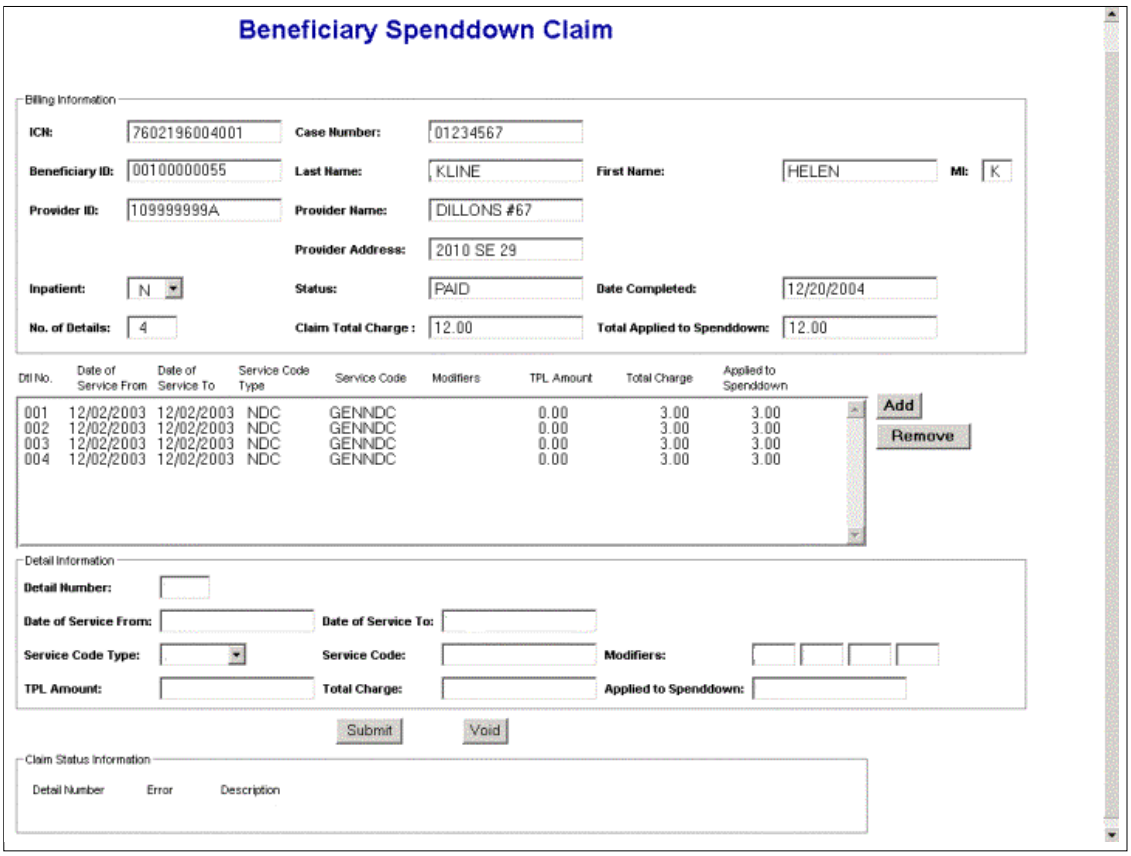
Helen has a Medically Needy spenddown of $175 for the base period of December through May. Helen met her spenddown right away with a due and owing bill, but knows that she will be going back on spenddown in a few days when we adjust her income with the COLA for January. Helen really needs help with her prescription costs. She takes a number of regular medications, so she sends in verification of her $3.00 Medicaid co-payments from Dillon's #67 to be applied to the increased spenddown.

Action

✓ The worker verifies the date of service, prescriptions, and Medicaid co-payment amounts. In order to enter the prescription co-payment amounts, the pseudo NDC code must be used on the **Beneficiary Spenddown Claim window,** as using the actual NDC for the drug would cause duplicate claim editing.

✓ Helen's spenddown was met and Beneficiary Billed Claims aren't supposed to be entered on the MMIS if the spenddown is met. However, Helen will go back to spenddown status with the COLA, so these expenses can be entered prior to the budgeting of the higher income or at the same time of the COLA adjustment. The co-pays would apply to her increased spenddown amount in either situation.

✓ The worker completes the **Beneficiary Spenddown Claim window.** The completed window is shown here:



A Sample Of Non-Medicaid Provider Eye Doctor Expenses

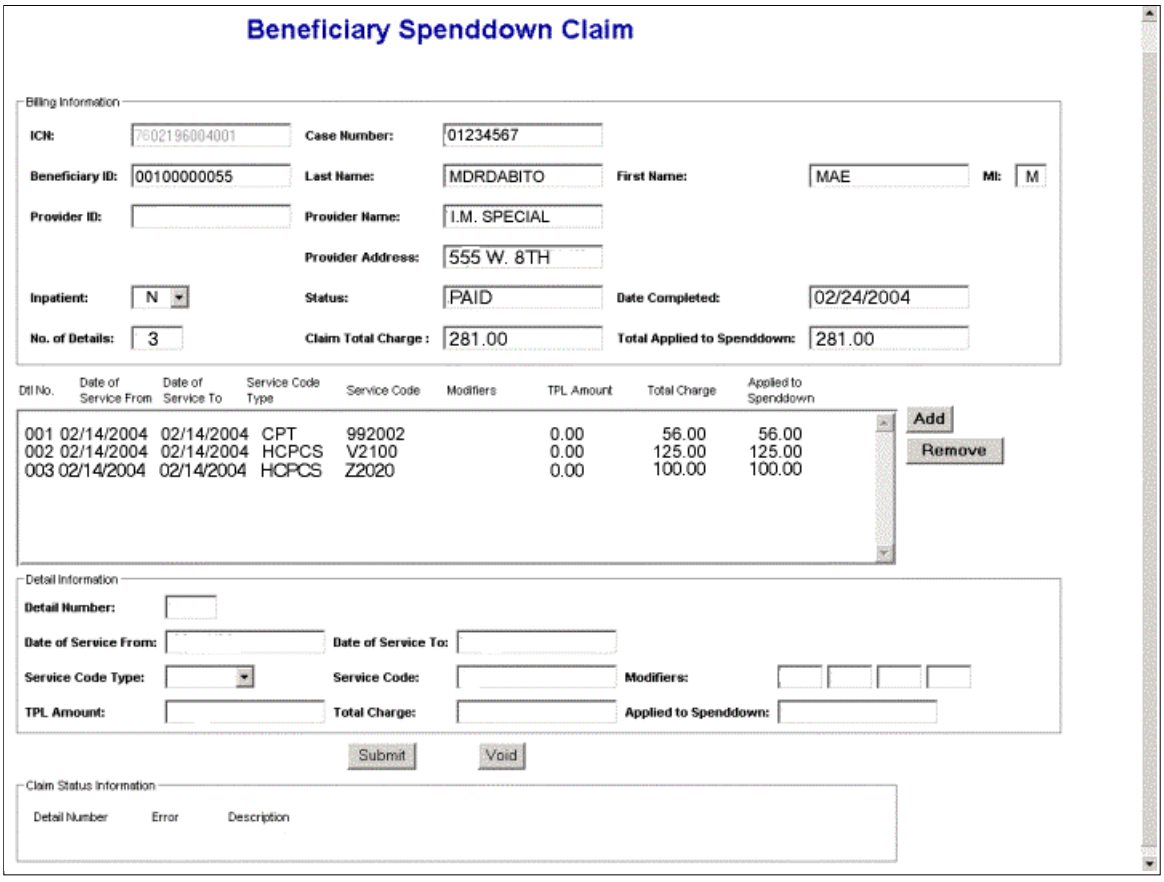
Mae has a Medically Needy spenddown of $245 for January through June and she has received her spenddown medical card. Mae needs to get new eye glasses. She has checked and knows they can't be covered by Medicaid. Also, Mae's optometrist does not accept Medicaid. Mae calls her eligibility worker to find out what to do as her appointment is coming up.

Action

- ✓ The eligibility worker explains the beneficiary billing process to Mae and sends her a blank self-bill form to have her optometrist complete. Mae goes to the eye doctor, gets the form completed, and sends it to her eligibility worker immediately.

- ✓ The eligibility worker reviews the ES-3170 to make sure it is complete and verifies that no other TPL coverage is available for the expenses.

- ✓ The worker completes the **Beneficiary Spenddown Claim window.** The completed window is shown here:



A Sample Of Non-Medicaid Provider Dental Expenses

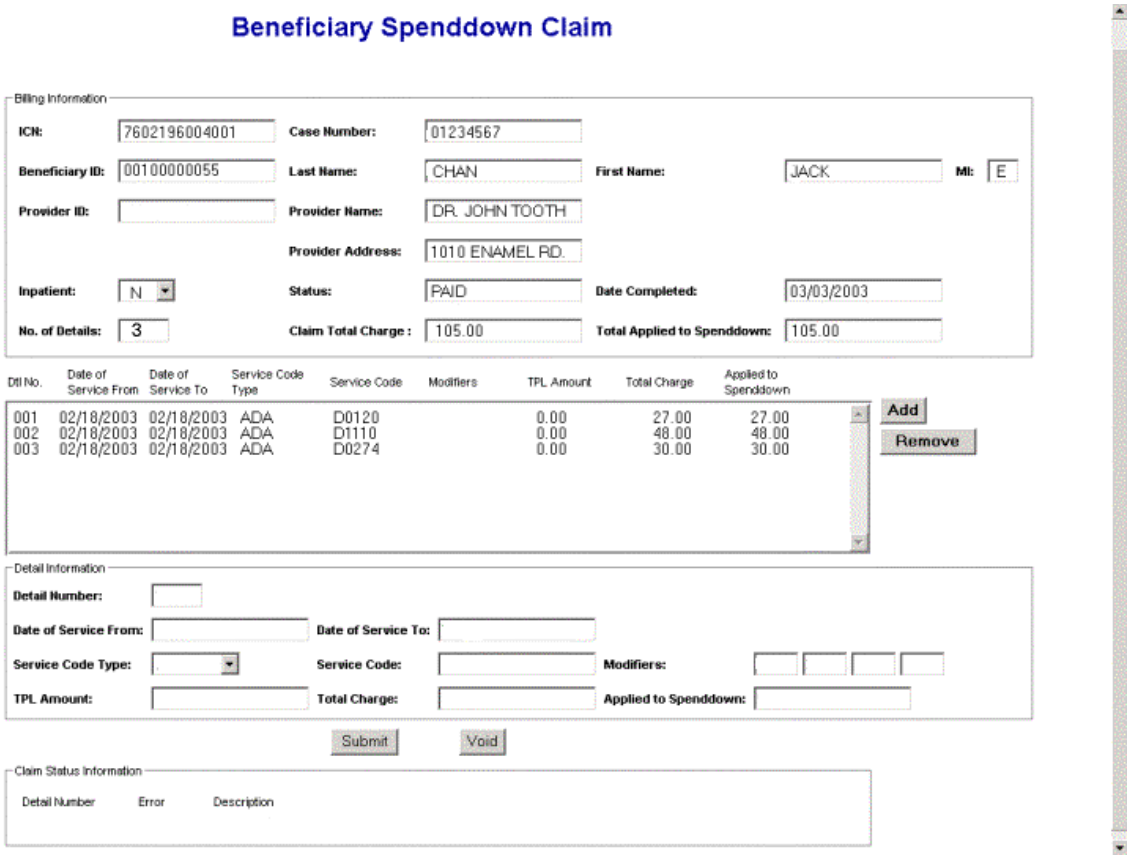
Jack has an open Medically Needy case with a spenddown of $109 for February through July. He has not met his spenddown and sends in a bill from his Non-Medicaid Dentist for a $27 routine exam, $48 for a dental cleaning, and $30 for bite wing x-rays. The bill also has all of the procedure codes listed.

Action

- ✓ In Jack's case, the bill has all of the necessary data. But, this may not always be the case, and the eligibility worker may have to contact the provider, consumer, or their Medicaid Liaison for assistance in obtaining necessary procedure codes.

- ✓ The eligibility worker must verify that no other TPL coverage is involved.

- ✓ The worker completes the **Beneficiary Spenddown Claim window.** The completed window is shown here:



A sample of Medically Necessary Items from Appendix P-1

Elizabeth has an open Medically Needy case with a spenddown of $325 for January through June. In the past, Elizabeth has had many expenses for over-the-counter items for which her doctor has verified as medically necessary. You explain to Elizabeth how the new spenddown process works, but she is happy using Big Time Drug and Market since they are so close to her residence even though they do not accept Medicaid.

On January 10th, you receive Big Time Drug and Market receipts for the following medically necessary items. You have prior documentation in the file that all are considered medically necessary for Elizabeth.

January 3rd - Aspirin purchased for $6.99
January 3rd - Incontinence supplies purchased for $13.99
January 3rd - Claritin purchased for $9.99
January 5th - TED Hose purchased for $27.99
January 5th - Ensure diet supplement purchased for $9.49

Action

- ✓ The worker calls their Medicaid Liaison or Big Time Drug and Market to get the procedure code type, code, and modifiers for each of the above listed services (if the bill presented by the consumer does not have this data).

- ✓ The worker completes the **Beneficiary Spenddown Claim window.** The completed window is shown here:

VOIDING BENEFICIARY BILLED CLAIMS

If you discover an error on a claim that has already been submitted, it will need to be voided and re-entered correctly.

There are other instances where eligibility workers will be using the 'Void' feature for Beneficiary Billed Claims. Specifically, voiding is used for consumers who have had a claim allowed as Beneficiary Billed Claim in an unmet spenddown, but later request that the same claim be allowed as a past due and owing expense in a later base period. If the expense is verified to be past due and owing and was not used to meet a previous spenddown, it can be allowed in the later base period. However, credit for the Beneficiary Billed expense must be removed from the previous base period by voiding the Beneficiary Billed Claim before it is allowed in the other base period (see pages 81-83).

THE VOIDING PROCESS

1. In the Claims subsystem of the MMIS, complete a search to locate the Beneficiary Billed Claim in question. Click on the box by the 'Beneficiary Only' field and an 'X' will appear in the box. This is the only way BB claims can be found.

2. Once the Beneficiary Billed Claim in question is located, note the claim's ICN number. (it should begin with the numbers 76)

3. Access the **Beneficiary Spenddown Claim window** and enter the claim's ICN number in the 'ICN' field. When tabbing forward or clicking on another field on the window, the entire claim's information should appear in the window.

4. Verify the correct claim by reviewing all of the details data. If it is not the right claim, complete another claims search until the correct claim is found.

5. To void the claim, click on the 'Void' button toward the bottom of the **Beneficiary Spenddown Claim window**. A display message should appear questioning if the user is certain they want the void transaction performed. Respond to this display message appropriately based on your intention to void the claim.

6. The claim has now been voided and the 'Status' field should show VOID as the payment status. If necessary, re-enter the claim with corrected information and click on the 'Submit' button. The corrected claim will be submitted to the MMIS and assigned a new ICN number.